BEFORE THE APPEALS BOARD
FOR THE
KANSAS DIVISION OF WORKERS COMPENSATION

TERRI LAWSON	)	
Claimant	)	
VS.	)	
	)	Docket No. 1,052,328
CONVERGYS	)	
Respondent	)	
AND	)	
	)	
FIDELITY & GUARANTY INSURANCE COMPANY	)	
Insurance Carrier	)	

ORDER

Claimant appeals the December 23, 2010, preliminary hearing Order of Administrative Law Judge Kenneth J. Hursh (ALJ). Claimant was denied benefits after the ALJ determined that claimant had failed to prove that she suffered personal injury by accident which arose out of and in the course of her employment.

Claimant appeared by her attorney, Mark E. Kolich of Lenexa, Kansas. Respondent and its insurance carrier appeared by their attorney, M. Joan Klosterman of Kansas City, Missouri.

This Appeals Board Member adopts the same stipulations as the ALJ, and has considered the same record as did the ALJ, consisting of the transcript of Preliminary Hearing held December 22, 2010, with attachments, and the documents filed of record in this matter.

ISSUE

Did claimant suffer personal injury by accident which arose out of and in the course of her employment with respondent? Claimant contends that she suffered an injury when she put her feet down off the wall when her chair began to move. Claimant testified that she felt a pop in her low back and low back pain shortly thereafter. Respondent contends that claimant's low back condition is attributable to surgery several years prior. Additionally, respondent contends the action of claimant immediately preceding the alleged injury was nothing more than a normal activity of daily living.

FINDINGS OF FACT

After reviewing the record compiled to date, the undersigned Board Member concludes the preliminary hearing Order should be affirmed.

Claimant began working for respondent's collection agency as a collector in April 2008.[1] This job was sedentary, requiring that claimant talk on the phone and use the computer all day. The job involved no heavy lifting.

On Tuesday, August 10, 2010, at 9:30 p.m., near the end of her shift, claimant was sitting with her feet on the wall of her cubicle when her wheeled chair began to move. Claimant put her feet down on the floor and felt a pop in her low back. A short time later, claimant's back began to hurt and claimant developed difficulty walking. Claimant finished her shift and may or may not have mentioned the injury to Brandon Wilson, her supervisor. Claimant then drove herself home, a 20- to 25-minute drive. When claimant left work that day, she called her husband when she arrived at her car because she was already sore. By the time claimant arrived home, she was in so much pain that she had to have her husband assist her into the house.

Claimant was scheduled to work the next day but was unable to do so. She called in to the automatic system phone line and left a message that she was not coming in due to the injury from the night before. The following Friday, August 13, 2010, claimant went to respondent's office to collect her paycheck. At the time, she talked to Laura Stuart, in respondent's human resources office, about the incident. Claimant was referred by Ms. Stuart to the company doctor. An Employee's Report of Incident/Illness was filled out that day. The report described the incident with the chair and the fact claimant felt a pop in her back when she put her feet on the ground and stood up.

Claimant was referred to Olathe Occupational Medicine Clinic where she was examined by Charles O. Smith, M.D., on August 13, 2010. Claimant described the chair incident to the doctor. She reported significant right-sided pain in her low back, with radiculopathy into her right lower extremity. Claimant also reported a past medical history of a disk herniation at L5-S1 with surgery six years prior. Claimant told Dr. Smith that she had done pretty good until the recent chair incident. She told Dr. Smith that she had some leftover Vicodin at home and she took one or two the day before (the day before the August 13 appointment with Dr. Smith). Since then, she was only taking over-the-counter Aleve. She was on no other medicine but the Vicodin and Aleve.

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[1] The Employee's Report of Incident/Illness says hire date April 2009. (See P.H. Trans., Res. Ex. D.) Claimant testified that she started with respondent in April 2007. But then claimant went on to testify that as of April [2011], she would have been with respondent for 3 years, which would mean that she started in April 2008. (See P.H. Trans. (Dec. 22, 2010), at 7.)

During the examination, claimant used a walker and was having difficulty walking and standing. She displayed a positive straight leg raising test on the right, with pain to the knee. X-rays indicated disk space narrowing at L5-S1. Claimant was taken off work and provided Tramadol for pain and Naproxen Sodium, with a return visit scheduled for August 16, 2010. Dr. Smith recommended a current MRI and requested the opportunity to review the MRI from claimant's earlier surgery. By the August 17, 2010 visit, claimant displayed no improvement, which surprised Dr. Smith. Claimant complained of significant pain down her right leg. Claimant had been off work and was doing no activity. Claimant's right leg raising test was only mildly positive. Claimant continued to use the walker, but displayed no evidence of muscle atrophy or wasting of her right lower extremity. Claimant was referred for an MRI and remained off work and on the medications from the first visit.

During the August 20, 2010, visit with John E. Carter, M.D., at the Olathe Occupational Medicine Clinic, claimant complained of significant pain, worse since the initial injury. The pain medication and anti-inflammatories provided no relief. Claimant described pain going to her foot, but when asked to indicate the location in the foot, claimant determined it was not actually going into the foot. She again discussed the earlier injury and surgery, and stated that she had no restrictions or problems from that incident. During the examination, claimant was tearful and ambulated slowly with the aid of a walker. However, while seated, claimant displayed no pain with passive internal or external rotation of her hips. Straight leg raising in the seated position was 90 degrees, and there was no significant radiation of pain with the straight leg raising test. The MRI displayed no evidence of recurrent disk herniation, but post-surgical changes of the right L5 laminectomy and microdiskectomy were evident. Lumbar spondylosis at L5-S1 with mild right neural foraminal stenosis was also noted. There was also a right pelvic cyst, which was possibly an ovarian follicular cyst. Claimant was diagnosed with a lumbar strain. Dr. Carter recommended that claimant be treated with a Medrol Dosepak for the pain. He also opined that claimant could return to modified duty as a collector for respondent with a few limitations. Apparently, claimant's husband became upset when he learned that claimant had been returned to work. Personnel in the doctor's office indicated that he exhibited aggressive and threatening behavior, and the police may have been called. There are no records to indicate that claimant returned to Dr. Smith's or Dr. Carter's office after August 20, 2010.

Claimant was sent by her attorney to board certified orthopedic surgeon Edward J. Prostic, M.D., on October 1, 2010. The injury history provided to Dr. Prostic was the same as before. Dr. Prostic indicated in his report that, according to the history, the MRI displayed post-surgical changes on the right at L5-S1. Claimant did discuss some recurrent pain from the prior surgery. She was treated by Dennis Katz, D.O., of the Pain Management Institute. During the examination by Dr. Prostic, claimant displayed mild tenderness with limited range of motion. Claimant displayed no weakness in either leg and sensation was satisfactory. There was mild hamstring tightness bilaterally, both seated and supine. The MRI showed a small disk protrusion at L5-S1 on the right, level

with the scar. Dr. Prostic diagnosed an aggravation of the preexisting disk disease at L5-S1. Claimant was instructed to continue with her current medications.

Claimant returned to work for respondent in late August 2010. She testified that her back continues to bother her. Claimant also testified that taking the pain medication while working makes it hard to work. But if she does not take the medication, the pain is significant.

Claimant was questioned regarding her past back problems. Surgery was performed by C. M. Striebinger, M.D., involving a lumbar laminectomy and disk excision at L5-S1. As of January 10, 2006, Dr. Striebinger reported that claimant was off all medication and had returned to work.

Claimant acknowledged that she started having some back discomfort and went to Fernando M. Egea, M.D. Claimant then transferred to the physicians at Mid-America Physiatrists, P.A. Claimant acknowledged that she had intermittent pain and was treated periodically with pain medication. However, her pain before this accident was only intermittent. Currently, the pain is constant. Claimant was on Soma, a muscle relaxer; Neurontin, a nerve pill; oxycodone; and Xanax. Claimant testified that she only takes the oxycodone once a day.[2]

Claimant agreed that she had testified during her deposition that on the evening of the accident, her chair had been moving all evening. Additionally, when claimant returned to work for respondent, she did not talk to anyone about the chair and was still using the same chair.

Claimant's medical history indicates that there was an occasion several years ago where claimant's back popped while she was walking.[3] At that time, claimant needed pain medication and began going to Dr. Egea because her husband was going to him after an automobile accident. For at least the last two years that claimant was seeing Dr. Egea, he had been prescribing claimant 200 oxycodone a month, with claimant renewing the prescription every month. Yet claimant still denied taking oxycodone more than once a day. Dr. Egea diagnosed chronic lumbar pain syndrome on October 28,

[2] Claimant testified that it was "once or twice", but then she went on to testify that it was actually only "once." (See P.H. Trans. at 22-23 & 30)

[3] At the preliminary hearing, there was an indication that this happened possibly in 2006. (See P.H. Trans. at 29.)

2009.[4] [5] In the spring of 2010, Dr. Egea lost his license to practice medicine due to improperly providing narcotic pain medication to DEA agents. The last prescription from Dr. Egea was in March 2010. Claimant was then referred to the Pain Management Institute, where claimant was treated by Dennis Katz, D.O.

Claimant first saw Dr. Katz on June 18, 2010, at which time claimant advised him that she was taking Xanax, three times a day; Percocet, four times per day; Cymbalta; and Lyrica, three times per day. The pain medication was for lumbosacral radiculopathy, muscle spasms and low back pain. The medication was necessary as claimant was experiencing pain into her buttocks, with the pain level at 5 to 8 out of 10. Claimant had undergone eight epidural injections with minimal effect. Claimant had undergone physical therapy, massage therapy, electrical therapy, acupuncture and chiropractic therapy with no improvement. Claimant had been on Xanax four times per day, which was seen as excessive. On physical examination, claimant was seen to drag her right leg while walking.

Claimant was seen by Steven Simon, RPh., M.D., on July 7, 2010. The report indicates that claimant was being seen for failed back surgery syndrome. Claimant advised that the medications provided by Dr. Katz were ineffective. However, the urinalysis, done at her last visit, indicated that, while claimant was using the oxycodone, there were no opioids in her urine. This indicated that claimant was not taking all the medications. Claimant was advised to take the adjuvant medication, as well as the pain medication. On physical examination, claimant was seen to drag her left foot while walking.

Claimant was next examined by Dr. Katz on August 25, 2010. At this time, approximately 15 days after the alleged accident with respondent, claimant told the doctor that her pain level was at 4 to 5 on a scale of 10. Claimant was supposed to be seeing Dr. Grossman, a psychologist, for overuse of the anxiety medication Xanax; however, claimant had not seen him due to money concerns. Claimant was again diagnosed with post laminectomy syndrome, low back pain, lumbosacral radiculopathy and muscle spasms. There was no mention of the alleged accident at respondent. On examination, claimant was noted to drag her left foot while walking. There was no mention of claimant using a walker. When Dr. Egea diagnosed claimant with chronic lumbar pain syndrome, she was told that her back would never get better.[6]

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[4] See P.H. Trans., Resp. Ex. A.

[5] At the preliminary hearing, claimant acknowledged that Dr. Egea diagnosed her with failed back syndrome in the spring of 2010. (See P.H. Trans. at 42-43.)

[6] At the preliminary hearing, claimant acknowledged that Dr. Egea diagnosed her with failed back syndrome in the spring of 2010, and she testified that Dr. Egea told her that her back would never get better. (See P.H. Trans. at 42-43.) On October 28, 2009, Dr. Egea diagnosed claimant with chronic lumbar pain syndrome. (See P.H. Trans., Resp. Ex. A.)

PRINCIPLES OF LAW AND ANALYSIS

In workers compensation litigation, it is the claimant's burden to prove his or her entitlement to benefits by a preponderance of the credible evidence.[7]

The burden of proof means the burden of a party to persuade the trier of fact by a preponderance of the credible evidence that such party's position on an issue is more probably true than not true on the basis of the whole record.[8]

> If in any employment to which the workers compensation act applies, personal injury by accident arising out of and in the course of employment is caused to an employee, the employer shall be liable to pay compensation to the employee in accordance with the provisions of the workers compensation act.[9]

The two phrases "arising out of" and "in the course of," as used in K.S.A. 44-501, et seq.,

> . . . have separate and distinct meanings; they are conjunctive and each condition must exist before compensation is allowable. The phrase "in the course of" employment relates to the time, place and circumstances under which the accident occurred, and means the injury happened while the workman was at work in his employer's service. The phrase "out of" the employment points to the cause or origin of the accident and requires some causal connection between the accidental injury and the employment. An injury arises "out of" employment if it arises out of the nature, conditions, obligations and incidents of the employment."[10]

K.S.A. 2010 Supp. 44-508(d) defines "accident" as,

> . . . an undesigned, sudden and unexpected event or events, usually of an afflictive or unfortunate nature and often, but not necessarily, accompanied by a manifestation of force. The elements of an accident, as stated herein, are not to be construed in a strict and literal sense, but in a manner designed to effectuate the purpose of the workers compensation act that the employer bear the expense of accidental injury to a worker caused by the employment.[11]

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[7] K.S.A. 2010 Supp. 44-501 and K.S.A. 2010 Supp. 44-508(g).

[8] *In re Estate of Robinson*, 236 Kan. 431, 690 P.2d 1383 (1984).

[9] K.S.A. 2010 Supp. 44-501(a).

[10] *Hormann v. New Hampshire Ins. Co.*, 236 Kan. 190, 689 P.2d 837 (1984); *citing Newman v. Bennett*, 212 Kan. 562, Syl. ¶ 1, 512 P.2d 497 (1973).

[11] K.S.A. 2010 Supp. 44-508(d).

Injury or personal injury has been defined to mean,

> . . . any lesion or change in the physical structure of the body, causing damage or harm thereto, so that it gives way under the stress of the worker's usual labor. It is not essential that such lesion or change be of such character as to present external or visible signs of its existence.[12]

The record supports a finding that claimant experienced an incident on August 10, 2010. However, merely having this type of experience does not constitute an accident or an injury. While the experience described by claimant might, by the barest of margins, constitute an accident, this record does not support an injury resulting from that accident. The medical findings from claimant's examinations, after this incident, with Dr. Smith and his associates mirror the findings of the multitude of doctors who examined and treated claimant before August 10, 2010. In fact, the records support a finding that claimant may have actually improved leading up to her examination on August 25, 2010. Claimant's failure to advise Dr. Smith and his associates of the extent of her prior problems, as well as her total failure to mention her alleged accident to Dr. Katz shortly after the date of the incident, speak to an attempt to mislead both sets of physicians. Additionally, claimant's failure to so advise the physicians, while receiving medications from both, appears dangerous to claimant's well-being. This record does not support a finding that claimant suffered any injury from the alleged accident on August 10, 2010. Claimant's physical condition after August 10, 2010, was no worse, and may actually have been improved when considering claimant's medical records. The denial of benefits by the ALJ is affirmed.

By statute, the above preliminary hearing findings and conclusions are neither final nor binding as they may be modified upon a full hearing of the claim.[13] Moreover, this review of a preliminary hearing Order has been determined by only one Board Member, as permitted by K.S.A. 2010 Supp. 44-551(i)(2)(A), unlike appeals of final orders, which are considered by all five members of the Board.

CONCLUSIONS

Claimant has failed to satisfy her burden of proving that she suffered personal injury by accident which arose out of and in the course of her employment with respondent on August 10, 2010. The denial of benefits by the ALJ is affirmed.

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[12] K.S.A. 2010 Supp. 44-508(e).

[13] K.S.A. 44-534a.

DECISION

WHEREFORE, it is the finding, decision, and order of this Appeals Board Member that the Order of Administrative Law Judge Kenneth J. Hursh dated December 23, 2010, should be, and is hereby, affirmed.

IT IS SO ORDERED.

Dated this ____ day of March, 2011.

HONORABLE GARY M. KORTE

c: Mark E. Kolich, Attorney for Claimant
M. Joan Klosterman, Attorney for Respondent and its Insurance Carrier
Kenneth J. Hursh, Administrative Law Judge